



UnitedHealthcare Community & State 2023 IHCP Works Annual Seminar

Hoosier Care Connect Health Plan

Prior Authorization

Presented by Jodie Hattery –VP Provider Relations IN, KY, and OH

United
Healthcare®

Agenda

- Admission Notification vs. Prior Authorization
- Introduction to Prior Authorization
- How to submit Advance/Admission Notification
- How to obtain a Prior Authorization for:
 - Medical
 - Behavioral Health
 - Vision
 - Dental
- How to dispute a Prior Authorization denial
- How to appeal a denial decision
- General appeal information for all service lines



Our Service Lines

- ❖ UnitedHealthcare (UHC)
- ❖ Optum Behavioral Health (OBH)
- ❖ March Vision
- ❖ UnitedHealthcare Dental





Admission Notification

Admission Notification: General Acute Care and Nursing facilities are required to notify UnitedHealthcare (UHC) when a member has been admitted into their facility. This must be done within 24 hours (also referred to as 'head in the bed') of member admission.

To notify UnitedHealthcare of an Admission

- Via Phone
- Via fax paper form
- Online via the Prior Authorization and Admission Notification (PAAN) tool
- Electronic Data Interchange (EDI) 278N Transaction (easiest and most preferred method)



Admission Notification - EDI 278N Transaction

- Use the Hospital Admission Notification (278N) transaction to exchange admission notification data between an inpatient facility and UnitedHealthcare in a standard format.
- It can be transmitted directly to UnitedHealthcare or through a clearinghouse in either batch or real-time format.
- To get started, contact your vendor or clearinghouse. Most clearinghouses already send 278N transactions to UnitedHealthcare and can work with you to submit notifications in the appropriate format.
- For additional information regarding the EDI 278N Transaction please visit our website at: [EDI 278N: Hospital Admission Notification | UHCprovider.com](https://www.uhcprovider.com/EDI-278N-Hospital-Admission-Notification).



Introduction to Prior Authorization

The process to request Prior Authorization differs slightly depending on the service line.

Medical

Behavioral
Health

Dental

Vision



Prior Authorization Requirements for Indiana Hoosier Care Connect

Prior Authorization: Requesting medical necessity review and approval before rendering a service is required by UnitedHealthcare policy for some services. It's required under the direction of the UnitedHealthcare Health Services Department and is an essential part of any managed care organization. Advance notification is required to give UnitedHealthcare timely communication of services so we can do a prospective, concurrent, and retrospective care review.

*Prior authorization is ***not required*** for emergency or urgent care.



Medical How to Check Prior Authorization Requirements

Providers can check Prior Authorization requirements at:

[UnitedHealthcare Community Plan of Indiana Homepage](#) | [UHCprovider.com](#)

UnitedHealthcare Community Plan of
Indiana Homepage

[Bulletins and Newsletters](#)

[Care Provider Manuals](#)

[Claims and Payments |
UnitedHealthcare Community Plan of
Indiana](#)

[Eligibility and Benefits](#)

[How to Join the UnitedHealthcare
network](#)

[Pharmacy Resources and Physician
Administered Drugs | UnitedHealthcare
Community Plan of Indiana](#)

[Policies and Clinical Guidelines](#)

[Prior Authorization and Notification](#)

[Provider Forms and References |
UnitedHealthcare Community Plan of
Indiana](#)

UnitedHealthcare Community Plan of Indiana Homepage

We know you don't have time to spare, so we put all the UnitedHealthcare Community Plan resources you need in one place. Use the navigation on the left to quickly find what you're looking for. Be sure to check back frequently for updates.

**Prior Authorization
and Notification
Resources**

[Learn more](#)

**Current Policies and
Clinical Guidelines**

[Learn more](#)

**Provider
Administrative
Manual and Guides**

[Learn more](#)

[Expand All](#) ↕



Prior Authorization and Notification | UnitedHealthcare Community Plan of Indiana

Last update: June 23, 2023

We have online tools and resources to help you manage your practice's notification and prior authorization requests.

Need to submit or check the status of a prior authorization request? Go to UHCprovider.com/priorauth to learn about our Prior Authorization and Notification tool.

[Go to Prior Authorization and Notification Tool](#)

Current Prior Authorization Plan Requirements

- [UnitedHealthcare Community Plan Prior Authorization Indiana Hoosier Care Connect - Effective July 1, 2023](#) 



Medical How to Check Prior Authorization Requirements cont.



[UnitedHealthcare Community Plan Prior Authorization Indiana Hoosier Care Connect - Effective July 1, 2023 \(uhcprovider.com\)](https://www.uhcprovider.com)

Prior Authorization Requirements for Indiana Hoosier Care Connect Effective July 1, 2023

General Information

This list contains prior authorization requirements for UnitedHealthcare Community Plan in Indiana health care professionals for inpatient and outpatient services. To request prior authorization, please submit your request online, or by phone

- **Online:** Use the Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal. Go to [UHCprovider.com](https://www.uhcprovider.com) and click on the UnitedHealthcare Provider Portal button in the top right corner. Then, select the Prior Authorization and Notification on your Provider Portal dashboard.
- **Phone:** 877-610-9785

Prior authorization is not required for emergency or urgent care. Out-of-network physicians, facilities and other health care professionals must request prior authorization for all procedures and services, excluding emergent or urgent care.

Prior authorization: Requesting approval before rendering a service, as required by UnitedHealthcare policy. It's required under the direction of the UnitedHealthcare Health Services Department and is an essential part of any managed care organization. Advance notification is required to give UnitedHealthcare timely communication of services so we can do a prospective, concurrent and retrospective care review.

Procedures and Services	Additional Information	CPT® or HCPCS Codes and/or How to Obtain Prior Authorization			
Bariatric	Prior authorization required	43644	43645	43659	43770
	There is a Center of Excellence requirement for coverage of bariatric surgery and services.	43771	43772	43773	43774
		43775	43842	43843	43845
		43846	43847	43848	43860
		43849	43850	43851	43852



Medical How to Check Prior Authorization Requirements Via PAAN

Use the Prior Authorization and Notification Tool via our UnitedHealthcare Provider Portal to:

- Determine if notification or prior authorization is required
- Complete the notification or prior authorization process
- Upload medical notes or attachments
- Check request status and advance notification/lists



Medical How to Check Prior Authorization Requirements via PAAN

From the www.uhcprovider.com homepage click on “Sign In”

Members  New User & User Access

What can we help you find? 



Eligibility Prior Authorization Claims and Payments Referrals Our network  Resources  **Sign In** 

After logging into our UnitedHealthcare Provider Portal, click on the “Prior Authorizations and Notifications” tab and select “Check if Required”

United Healthcare Training & Support Practice Management TrackIt JODIE

Search Payer 87726 - UnitedHealthcare Provider

Eligibility Claims & Payments Referrals **Prior Authorizations** Clinical & Pharmacy Documents & Reporting Additional Tools

Access Requests

Pending user requests  0 Expiring user requests  0 Pending 3rd party requests  0 Expiring 3rd party requests  0

Welcome, JODIE!

Before you get started, make sure your [payer information](#) and [provider information](#) in the top right corner of the page are correct. [Customize Tabs](#)

Action Required  0

Action Required
View and take action on items below that required attention.

Show only items that require action

Claims Smart Edits **0 Expiring Soon**

Prior Authorizations Additional clinical records needed **0 Require Action**



Medical How to Check Prior Authorization Requirements

On the next screen, select the Product Type, State, and Procedure Code

NOTIFICATION/PRIOR AUTHORIZATION PROCEDURE CODE INQUIRY

1 Inquiry Request 2 Inquiry Response

SUBMITTING PROVIDER

NAME TAX ID
Matt Johnson 123456789

SELECT A DIFFERENT PROVIDER

INQUIRY FORM * REQUIRED FIELDS

For medical services only. Behavioral Health requirements must be verified through <https://www.providerexpress.com>.
Please note the following exclusions:

- UnitedHealthcare SureT Plans.
- UnitedHealthcare Exchange Plan. Exchange Plan member benefits must be verified through <https://www.uhcprovider.com/exchanges>.
- Oxford members prior authorization requirements are not currently supported on this tool [Advance Notification and Clinical Submission Requirements | UHCprovider.com](#).
- For Home and Community Based Services, please call the number on the back of the member's ID card.

PRODUCT TYPE* STATE*

DIAGNOSIS CODE

PROCEDURE CODE*

At least one procedure code is required. Maximum of 5 codes is allowed.

[Add another procedure code](#)

CANCEL CONTINUE

The search executed is based on data that you have selected. Your search is not a request for prior authorization and is not notification to UnitedHealthcare. Prior authorization requirements vary by benefit plan and the provider's participation status. Your search does not guarantee coverage. Coverage determinations are based on the member's benefit plan and eligibility for benefits, in addition to other criteria.



Medical How to Request a Prior Authorization

- Online PAAN Tool
- Fax paper form
- Phone: 877-610-9785

The screenshot shows the UnitedHealthcare web portal for Prior Authorizations. At the top, the UnitedHealthcare logo is on the left, and navigation links for Training & Support, Practice Management, TrackIt, and JODIE are on the right. A search bar is located below the logo. On the right side, there are dropdown menus for Payer (87726 - UnitedHealthcare) and Provider. A dark blue navigation bar contains links for Eligibility, Claims & Payments, Referrals, Prior Authorizations (highlighted), Clinical & Pharmacy, Documents & Reporting, and Additional Tools. Below this is a section titled 'Access Requests' with four status indicators: Pending user requests (0), Expiring user requests (0), Pending 3rd party requests (0), and Expiring 3rd party requests (0). A 'Welcome, JODIE!' message is followed by a note to verify payer and provider information. A 'Customize Tabs' button is in the top right. The main content area is divided into three columns. The left column has 'Action Required', 'Eligibility', and 'Claims & Payments' sections. The middle column, 'Select a Task', has buttons for 'Create Request', 'View Existing', and 'Check If Required'. The 'Create Request' button is highlighted with a red box. Below it is a link to 'Create new submission for standard services not listed below' and a button labeled 'Create a new request' with an external link icon, also highlighted with a red box. A note below states: 'This includes all Medicaid Behavioral Health requests. All other behavioral health requests should be submitted as Provider/Consumer requests.' The right column, 'PAAN Resources', lists 'Tool resources', 'Interactive training guide', and 'Peer to peer requests'.



Medical Radiology/Cardiology Prior Authorization Requirements

Utilize the list available online (at the link below) to determine if a Radiology or Cardiology service requires Prior Authorization.

<https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/in/priorauth/IN-Hoosier-Connect-Effective-8-1-2023.pdf>

Search the list by utilizing Ctrl “+” F on your keyboard and typing in the CPT code that best represents the service to be performed.

Remember: For Radiology and Cardiology services, you will follow the same process that you do for all other medical services as seen in the previous slides.



Medical Prior Authorization Submission Tips

- If the provider you are trying to select is not an option, select another provider within the group for the authorization.
- Use the “Find Facility” search tool to locate the facility where the service will be performed.
- Use the wildcard symbol (*) to help you find the results you are looking for. Typing in less with a wildcard will help return the results you are looking for.
- UnitedHealthcare Community Plan uses InterQual for medical care determinations.
- You can access our UnitedHealthcare Community Plan of Indiana Clinical Guidelines [here](#)



Medical Tips to Avoid Prior Authorization Denials

Medical Management Guidelines

Admission authorization and guidelines

All prior authorizations must have the following:

- Be thorough and complete all the requested documentation
- Ensure that you are answering all authorization questions
- Patient name and Medical ID number
- Ordering care provider or health care professional name and TIN/NPI
- Rendering care provider or health care professional and TIN/NPI
- ICD-10 Diagnosis Codes
- Anticipated date(s) of service
- Primary and secondary procedure code(s) and number of units or visits, etc., when applicable
- Service setting
- Facility name and TIN/NPI, when applicable



- Problem: UHC does not receive ***routine*** Prior Authorization requests for scheduled services well in advance of the service date.
 - Submit your Prior Authorization request online, via the PAAN tool as soon as the service/procedure is scheduled. For example, if a surgery is scheduled two months in advance, submit the Prior Authorization as soon as possible after scheduling. This will result in a timely determination well in advance of the scheduled service date.



Medical Avoiding Adverse Determinations and/or Peer-to-Peer Reviews

- Problem: UHC often does not receive complete clinical information with the authorization request to make a medical necessity determination
 - Following the suggestions below will result in less adverse determinations, more timely decision turn-around-times, a reduction in the need for Peer-to-Peer reviews, and/or requests for additional clinical information:
 - Submitting Prior Authorizations online via the PAAN tool
 - Submission of all required clinical information
 - Completion of all fields within the online request leaving no fields blank and avoiding answering with “N/A”



Medical How to Appeal an Adverse Decision

If providers request is denied, they may request a Peer-to-Peer by calling 800-955-7615.

If provider disagrees with the Peer-to-Peer decision, they may file an appeal. Even if a Peer-to-Peer is not completed, provider may still file an appeal. All steps in the process are outlined in the decision letter sent by the authorization team.

Escalate to the Advocate team if it is taking longer than the state mandated turn around time to receive a decision.



Medical Peer-to-Peer Process

- Peer-to-Peer reviews can be requested 7 calendar days from verbal notification of an adverse determination (this includes Inpatient Level of Care denials.)
- A Peer-to-Peer review should be requested by facilities when Inpatient Level of Care is denied.
- A Peer-to-Peer review can also be requested if a Prior Authorization for a scheduled procedure is denied.
- A Prior Authorization request that does not meet coverage criteria or lacks sufficient information upon submission may “pend” for a Peer-to-Peer



Prior Authorization Decision Turn-Around-Times

Type of Request	Decision TAT	Practitioner Notification of Approval	Written Practitioner/Member Notification of Denial
Non-urgent Pre-service	Within 7 calendar days of receipt of medical record information required but no longer than 14 calendar days from receipt	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/Expedited Pre-service	Within 48 hours of request receipt	Within 48 hours of the request	Within 48 hours of the request
Concurrent Review	Within 1 business day	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within two business days
Retrospective Review	Within 30 calendar days of receiving all pertinent clinical information	Within 30 days of determination	Within 30 days of determination



Medical Avoiding Adverse Determinations and/or Peer-to-Peer Reviews

As mentioned previously, completion of all fields within the online request, leaving no fields blank, and avoiding answering questions with “N/A”, will result in more timely decisions.

The best way to accomplish this is to be familiar with the Clinical/Medical Policies that apply to the service you are requesting Prior Authorization for.

For example, a provider that specializes in Bariatric Surgery should be familiar with our Community Plan of Indiana’s “Bariatric Surgery” Medical Policy.



Medical Clinical Policies - Example

Indiana Medicaid Bariatric Surgery Medical Policy

[Surgical Services Provider Reference Module](#)

Bariatric Surgery and Revisions

Bariatric surgery is recognized as medically necessary when used for the treatment of morbid obesity. Providers must report ICD-10 diagnosis code E66.01 – *Morbid obesity* with the most specific procedure code available that represents the procedure performed.



Medical Be Familiar with our Clinical Policies

- Providers can view our Clinical Policies [here](#)

UnitedHealthcare Community Plan of
Indiana Homepage

[Bulletins and Newsletters](#)

[Care Provider Manuals](#)

[Claims and Payments |
UnitedHealthcare Community Plan of
Indiana](#)

[Eligibility and Benefits](#)

[How to Join the UnitedHealthcare
network](#)

[Pharmacy Resources and Physician
Administered Drugs | UnitedHealthcare
Community Plan of Indiana](#)

[Policies and Clinical Guidelines](#)

[Prior Authorization and Notification](#)

[Provider Forms and References |
UnitedHealthcare Community Plan of
Indiana](#)

UnitedHealthcare Community Plan of Indiana Homepage

We know you don't have time to spare, so we put all the UnitedHealthcare Community Plan resources you need in one place. Use the navigation on the left to quickly find what you're looking for. Be sure to check back frequently for updates.

**Prior Authorization
and Notification
Resources**

[Learn more](#)

**Current Policies and
Clinical Guidelines**

[Learn more](#)

**Provider
Administrative
Manual and Guides**

[Learn more](#)

[Expand All](#) 



Medical Be Familiar with Clinical Policies

- Bariatric Surgery
- UHC follows in this order:
 - State and Federal Medical Policy Regulations
 - UnitedHealthcare Medical Policy
 - InterQual Medical Policy

[Bariatric Surgery \(for Indiana Only\) – Community Plan Medical Policy](#)

Last Published 04.01.2023

Effective Date: 04.01.2023 – This policy addresses bariatric surgery.



Medical Clinical Policies

- UHC Medicaid Bariatric Surgery Medical Policy
- <https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan/in/bariatric-surgery-in-cs.pdf>



UnitedHealthcare® Community Plan
Medical Policy

Bariatric Surgery (for Indiana Only)

Policy Number: CS007IN.03
Effective Date: April 1, 2023

[Instructions for Use](#)

Table of Contents	Page
Application	1
Coverage Rationale	1
Applicable Codes	1
U.S. Food and Drug Administration	3
References	4
Policy History/Revision Information	4
Instructions for Use	5

Related Policies
None



Medical Process to Dispute a Prior Authorization Decision & File Appeal

- When there is an initial adverse determination of a prior authorization request:
 - Provider's next available step is a Peer-to-Peer review
 - If the denial is upheld, the provider can then appeal the determination
 - If no Peer-to-Peer was requested and an appeal was filed, then the provider is no longer eligible for a Peer-to-Peer
 - Provider will receive a letter of adverse determination; it will detail steps needed to request a Peer-to-Peer and/or an appeal



Medical External Review

- When requested, an external review of a Prior Authorization can be performed by an Independent Reviewer Organization (IRO)
- Member must file the external review request within 120 calendar days from receiving the appeal decision
- We utilize the State's recommended list of Independent Review Organizations (IROs) to conduct the external review
- A decision by the IRO is made within 72 hours if expedited and within 15 business days for standard appeals
- The decision by the IRO is binding and not disputable by UnitedHealthcare



Medical State Fair Hearings

- FSSA maintains a fair hearing process which allows members the opportunity to appeal the Contractor's decisions. Members can find out how to submit a request for a State Fair Hearing [here](#).
- Members must first exhaust all grievance and appeal options with UnitedHealthcare.
- Members may file for a State Fair Hearing within 120 calendar days from the adverse determination notice of the final appeal.
- The member and member's representative as well as a representative of UnitedHealthcare attends the hearing.
- If the member is dissatisfied with the outcome of the hearing, they may request an Independent Review Organization (IRO) review within 10 days of the administrative law judge's decision.



Medical Retroactive Authorizations & Medical Claim Review

- Retroactive Authorization:
 - Retroactive Authorizations will be issued when the “No Authorization” denial was due to eligibility issues
- Medical Claim Review (MCR) performs Medical Necessity reviews on denied claims when a Prior Authorization/Admission Notification was not obtained or if Inpatient Level of Care was denied during the members inpatient stay
 - Example: Provider obtains authorization for a particular code, then upon entering the surgical site the provider must perform an additional or different service than what was originally approved
 - The claim would be filed, denied and then reviewed by the Medical Claim Review team upon submission of a Claim Reconsideration with documentation that supports medical necessity attached



BEHAVIORAL HEALTH



Behavioral Health

How to determine if a Behavioral Health Service Requires Prior Authorization

- Most outpatient Behavioral Health services do NOT require an authorization
- Call the number on the back of the member's card to determine if authorization is required
- Or check online at: [Provider Express - Indiana Medicaid](#)

The screenshot shows the Optum Provider Express website interface. At the top, there is a navigation bar with links for Home, Our Network, Clinical Resources, Admin Resources, Video Channel, Training, About Us, and Contact Us. A search bar is located in the top right corner. The main content area is titled 'Welcome to the Optum Network!' and features several sections: 'Optum Network Manual', 'Best Practice Guidelines', and 'Automated/Applied Behavior Analysis'. The 'Indiana Medicaid-Specific Resources' section is highlighted with a blue arrow pointing to a list of links for prior authorization forms, including 'Universal Prior Authorization Form', 'Substance Use Disorder (SUD) Universal Prior Authorization Form', 'IHCP SUD Admission Assessment Form', 'IHCP SUD Reassessment Form', 'Psych-Neuropsych Prior Authorization Request Form', and 'UNITED HEALTHCARE COMMUNITY PLAN OF INDIANA HOOSIER CARE CONNECT BEHAVIORAL HEALTH PRIOR AUTHORIZATION LIST'. Below this list, there is a link for 'For appeals information: [uhcprovider.com/indiana](#)'.



Behavioral Health

How to request Behavioral Health Prior Authorization

- Initiate phone authorization process by calling 877-610-9785 or the number on the back of the member's ID card.
- Securely login to Provider Express and select “Auth Request” from the “Auths” dropdown box
- To check on status, select “Auth Inquiry”
- Utilize the paper Universal Prior Authorization Form from [Provider Express - Indiana Medicaid](#) and clicking “Prior Authorizations and Appeals”
- Fax to 844-897-6514

The screenshot shows the Optum Provider Express interface. At the top, there are navigation links: 'Elig & Benefits', 'Claims', 'Auths', 'Appeals', 'My Practice Info', and 'More'. The 'Auths' dropdown menu is open, showing 'Auth Request' and 'Auth Inquiry' options. Below the navigation, there is a 'Welcome to Provider Express!' message and a 'Find Member Eligibility & Benefits' section. This section includes search filters for 'My Patients', 'Member ID Search', and 'Name/DOB Search'. A table below the filters lists patient information with columns for 'Select All', 'First Name', 'Last Name', 'Member ID', 'Birth Date', and 'State'. The table contains five rows of placeholder data.

▼ Prior Authorizations and Appeals

For BH prior authorization, please submit the Universal PA form to 844-897-6514.

- [Universal Prior Authorization Form](#)
- [Substance Use Disorder \(SUD\) Universal Prior Authorization Form](#)
- [IHCP SUD Admission Assessment Form](#)
- [IHCP SUD Reassessment Form](#)
- [Psych-Neuropsych Prior Authorization Request Form](#)

For appeals information: uhcprovider.com/Indiana



Behavioral Health

How to request Prior Authorization for ABA Therapy Services

Optum | Provider Express

Log In | First-time User | Global | Site Map

Search: Search

Home Our Network Clinical Resources Admin Resources Video Channel Training About Us Contact Us

[Optum - Provider Express Home](#) > [Our Network](#) > [State-Specific Provider Information](#) > Welcome Indiana

Welcome to the Optum Network!

Optum Network Manual

- [Network Manual](#)

Best Practice Guidelines

- [BP Guidelines](#)

Autism/Applied Behavior Analysis

- [Indiana Medicaid ABA Program](#)

InterQual Level of Care Guidelines are used and criteria can be provided upon request for specific cases.

ASAM Level of Care Guidelines are used for Substance Use Disorder (SUD).

Additional information and forms are available, including psych/neuropsych testing guidelines, credentialing plans, and Disability Solutions Manual, on the Provider Express [Guidelines/Policies & Manuals](#) and [Optum Forms](#) pages.

Indiana Medicaid-Specific Resources

- Provider Communications and General Resources
- Claims
- Prior Authorization and Appeals
- Training Resources
- Contacts

Optum | Provider Express

Home Our Network Clinical Resources Admin Resources Video Channel Training

[Optum - Provider Express Home](#) > [Clinical Resources](#) > [Autism/Applied Behavior Analysis](#) > Indiana Medicaid ABA Program

Indiana Medicaid ABA Program

Optum is excited to announce that **UnitedHealthcare Community Plan of Indiana** has been awarded a contract to service the Indiana. Optum has been selected by UnitedHealthcare Community Plan to develop and manage the ABA network for Indiana network helps to ensure access to comprehensive quality care for covered behavioral health services for enrolled members.

- [Indiana Medicaid ABA Provider Orientation](#)
- [Indiana Medicaid ABA Quick Reference Guide](#)
- [ABA Treatment Request Form](#)
- [ABA Treatment Request Form](#) (Electronic Submission)

Contact Us/Request to Join the Network

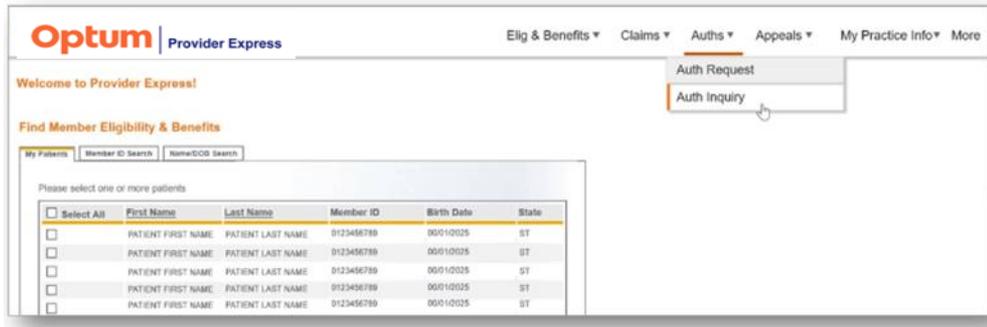
Nacole Thompson
Specialty Network Manager
nacole.thompson@optum.com

Provider Express - Indiana Medicaid



If provider submits a Prior Authorization request and does not receive a response within the required turn-around-time; do the following:

1. Check the Provider Express portal



2. Call the number on the back of the member's ID card
3. If 1 and 2 do not provide a response, please reach out to your Optum Behavioral Health Advocate



In the event an authorization is denied, and an appeal is necessary, make sure to include the following information with the appeal:

- Member Name
- Member Date of Birth
- Member RID
- PA Request
- Denial letter
- Any additional supporting documentation and send to:

National Appeals Team

Attn: Appeals Department/Retrospective Review

P.O. Box 30512

Salt Lake City, UT 84130-0512

Fax: (855) 312-1470

Phone Number: (866) 556-8166



DENTAL



Dental Summary of Dental Services requiring Prior Authorization



- Endodontics (root canals, root treatments)
- Periodontics (gum tissue treatment)
- Prosthodontics (dentures)
- Oral surgery (extractions, correction of oral issues)
- Orthodontics (braces), and moderate/deep sedation anesthesia



Dental

How to determine if a Dental Service requires Prior Authorization

- For a complete listing of procedures requiring authorization, refer to the benefit grid in the UnitedHealthcare Community Plan of Indiana Hoosier Care Connect Dental Provider Manual at www.uhcdentalproviders.com
- When requesting Prior Authorization, the practitioner must submit planned procedures for approval with clinical documentation supporting necessity before initiating treatment
- For questions concerning Prior Authorization, dental claim procedures, or to request clinical criteria, please call the Provider Services Line at **1-844-402-9118**



Dental How to request Prior Authorization

- Dental providers can submit Prior Authorization requests online at www.uhcdentalproviders.com
- They can also submit Prior Authorization requests via mail at the following address:

UnitedHealthcare Dental
Attn: Prior Authorization
P.O. Box 1313
Milwaukee, WI 53201

- Please include with the Prior Authorization request, a completed ADA Claim Form with the box titled “Request for Predetermination/Preauthorization” checked



Dental Authorization Timelines



The following Authorization timelines will apply to requests for authorization:



We will make a determination and provide written notification on *expedited authorizations* within 48 hours of receipt of the request.



We will make a determination and provide written notification on *standard authorizations* within 5 calendar days of receipt of the request.



Authorization approvals will expire 180 days from the date of determination.



VISION



Vision Prior Authorization



- March Vision Care does not require prior authorization for most routine vision services
- For routine exams, frames, and lenses, please check member eligibility and obtain a benefit confirmation on the www.eyesynergy.com provider portal
- For medically necessary contact lenses and fittings, providers need to submit a pricing request form



Vision How to request a March Vision Care Prior Authorization



- Obtain confirmation by logging into www.eyesynergy.com and search for member, verify eligibility & benefits, and generate a confirmation number
- Confirmation number is an 11-digit identification number generated when benefits & eligibility are verified
- Benefits that generally require confirmation numbers include, but are not limited to:
 - Replacement frames and lenses
 - Medically necessary contact lenses for Medicaid members
 - Two pairs of glasses in lieu of bifocals
 - Prescription sunglasses



Vision How to request a March Vision Care Prior Authorization



For medically necessary contact lenses, providers need to submit a pricing request form *prior* to submitting the claim for reimbursement. Email the completed form with the patient's current eye exam/doctor's notes to providers@marchvisioncare.com.

[Medically-Necessary-Form-Editable.pdf \(marchvisioncare.com\)](#)



Prior Authorization

Appeals process-all service lines

Medical

Behavioral
Health

Dental

Vision



Prior Authorization Appeals Process-All Service Lines



- All providers may appeal a Prior Authorization adverse determination
- An appeal can be filed within 60 calendar days from the date of the adverse determination
- Submitted appeals will be acknowledged within 3 business days



Prior Authorization Appeals Process-Outcomes



- A decision on the appeal is made within 30 calendar days unless it is expedited.
- Expedited appeals are resolved within 48 hours of receiving the appeal and every attempt is made to notify the member orally as well as in writing.
- A notification of standard appeal decision is sent within 5 business days of the resolution.
- In rare cases, a 14 calendar day extension may be required. If this is required, both the member and provider are notified.
- Appeal notification letters indicate how to file an appeal based on the type of service.



What are the options if the authorization is denied?

Utilization Management (UM) Appeals Process

- Peer to Peer within 14 days
Call 800-955-7615
- Next level appeal
- Fair Hearing

Type of Request	Decision TAT	Practitioner Notification of Approval	Written Practitioner/Member Notification of Denial
Non-urgent Pre-service	Within 7 business days of receipt of medical record information required but no longer than 14 calendar days from receipt	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/Expedited Pre-service	Within 48 hours of request receipt	Within 48 hours of the request	Within 48 hours of the request
Concurrent Review	Within 1 business day	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within two business days
Retrospective Review	Within 30 calendar days of receiving all pertinent clinical information	Within 30 days of determination	Within 30 days of determination



Medical Network Provider Advocate Team

Nneka Nelson
763-361-0100
nneka_m_nelson@uhc.com

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763-321-3822
lreeder@uhc.com

Kelly Carpenter
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Kelly_carpenter@uhc.com
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800-752-7106
SW_OH_team@uhc.com



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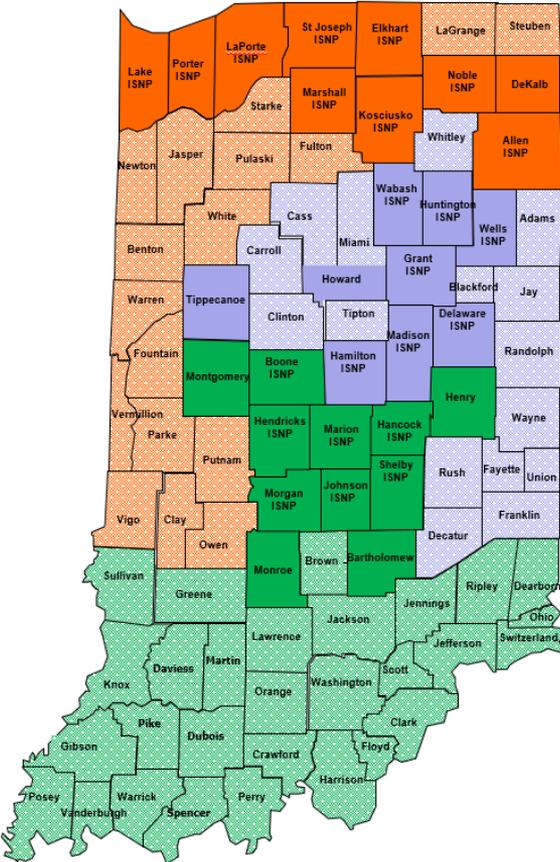
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jessica_iden@optum.com

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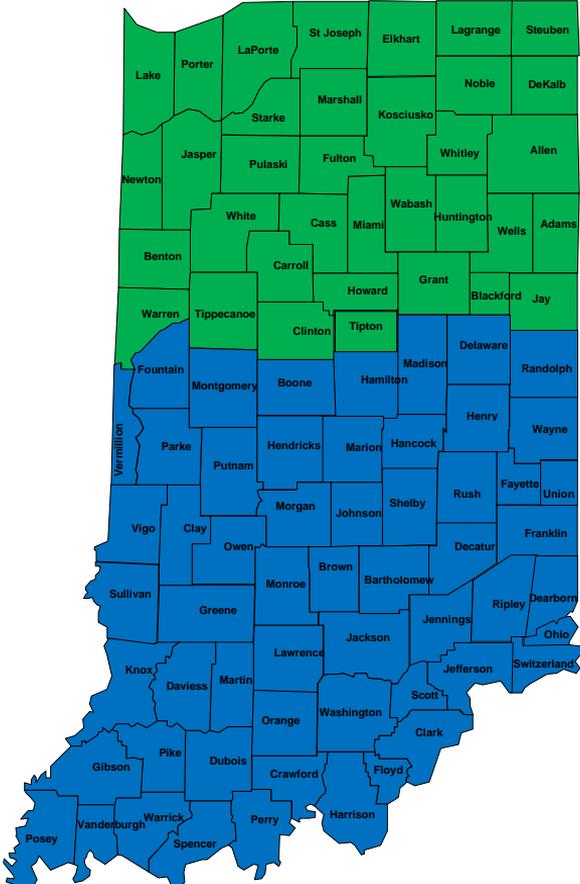


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Provider Reference Appendix



Provider Service Line Website Links

- United Health Community Plan (Medical): www.uhcprovider.com/INcommunityplan
- UHC Dental: www.uhcdentalproviders.com
- MarchVision: www.marchvisioncare.com
- Optum Behavioral Health: [Provider Express - Indiana Medicaid](#)



Questions and Answers

Thanks for Attending Today's Session

